STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155530	B. WIN	G		02/03	/2015
NAME OF F	ROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
SOUTHS	SHORE HEALTH &	REHABILITATION CENTER		353 TYI GARY,	LER ST IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000000							
F000000	This visit was for Complaint IN00 This visit was in Post Survey Revalues Investigation of completed on Decompleted on Decomple	or the Investigation of 162397. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with the visit (PSR) to the Complaint IN00161017 eccember 29, 2014. In conjunction with th	F00	0000 TAG	Please accept the following as the facility's credible allegation compliance. This plan does not constitute an admission of guiliability by the facility and is submitted only in response to regulatory requirements. The facility hereby respectfully requests a desk review of the alleged deficiencies noted in the survey.	n of not It or	DATE
	Census payor ty	pe:					
	Medicare: 11						
	Medicaid: 58						
	Other: 4						
	Total: 73						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155530	B. WING		02/03/2015
NAME OF I	PROVIDER OR SUPPLIE	2		ADDRESS, CITY, STATE, ZIP CODE	
SOUTH	SHORE HEALTH &	REHABILITATION CENTER		LER ST IN 46402	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	Sample: 5	LESC IDENTIFITING INFORMATION)	IAG		DATE
	Sample. 3				
	_	reflects State findings nce with 410 IAC			
	Quality review of 2015 by Jodi Mo	completed on Febraury 4, eyer, RN			
F000323 SS=D	The facility must environment remains hazards as is possible receives adequate assistance devices. Based on observinterview the fact adequate supervinterventions and 2 of 3 residents and 2 of 5. (Refindings included 1. On 2/3/15 at was observed site.)	RVISION/DEVICES ensure that the resident ains as free of accident sible; and each resident e supervision and s to prevent accidents. ration, record review, and cility failed to provide ision related to fall d devices not in place for reviewed for falls in the esidents #C and #D)	F000323	The facility will continue to enst that resident environments remain as free of accident hazards as is possible, and the residents receive adequate supervision and assistance devices to prevent accidents.  What corrective actions (s) who be accomplished for those residents found to have been affected by the deficient practice? Resident C is no longer a facility resident. An alarm box was immediately attached to Resident #D's	at vill

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

F0SX11

Facility ID: 000369

If continuation sheet Page 2 of 10

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	232) 1	.CLIII LL CC		COMPL	
ANDILAN	OI CORRECTION		A. BUI	LDING	00		
		155530	B. WIN	IG		02/03/	ZU10
NAME OF F	PROVIDER OR SUPPLIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWIND OF F	ACTIDER OR SULLEIE			353 TY	LER ST		
SOUTHS	SHORE HEALTH &	REHABILITATION CENTER		GARY,	IN 46402		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	attached to the v	wheel chair. There were			wheelchair. Further, a bed ala		
	no staff member	rs or visitors in the room			was and continues to be in pla	ace	
	at that time.				for Resident #D's bed.	_	
					Additionally, a padded cushio was immediately placed on the		
	On 2/3/15 at 10:	:05 a.m., LPN #1 assisted			seat of Resident #D's wheel of		
					and Dycem was immediately		
		standing position from			placed under the seat cushion	١.	
		There was a padded			Additionally, resident #D has		
		eat of the wheel chair.			been re-assessed and		
	There was no D	ycem on top of or under			appropriate interventions are	in	
	the seat cushion	. There was no wheel			place, based on current		
	chair alarm in pl	lace.			assessment. How other		
	r				residents having the potenti	al	
	The record for E	Resident #D was reviewed			to be affected by the same deficient practice will be		
					identified and what corrective	<b>10</b>	
		5 a.m. The resident's			action(s) will be taken? Fac	_	
	•	ded, but were not limited			residents will be re-assessed	-	
		eizures, high blood			charge nurses or designees to	-	
	pressure, and dia	abetes mellitus.			ensure that resident		
					environments continue to be	safe	
	The 2/2015 Phv	sician Order Statement			and free of accident hazards		
	1	There was an order for the			possible. As a result of reside		
		a Dycem (plastic film to			assessments/re-assessments		
		• •			individualized interventions wi		
		or sliding) pad on the			continue to be implemented o modified as indicated and	''	
		e order was originally			appropriate. Residents will		
		13. There was also an			continue to receive adequate		
	order for the res	ident to have wheel chair			supervision and appropriate		
	and bed alarms	in place. The order was			assistance devices to prevent	:	
	originally writte	-			accidents as is possible. What	at	
					measures will be put into pla		
	   The 12/7/14 Mii	nimum Date Set quarterly			or what systemic changes w		
		cated the resident's BIMS			be made to ensure the defic	ient	
					practice does not reoccur?		
	· ·	for Mental Status) score			Upon admission, new residen		
	` ′	e of (9) indicated the			will continue to be assessed to charge nurses or designees to	-	
	resident's cognit	rive patterns were			ensure that their environment		
	moderately impa	aired. The assessment			are free of accident hazards a		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPL	ETED
		155530	A. BUIL			02/03/	2015
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			LER ST		
SOUTLI	SUODE DEVITU 0	REHABILITATION CENTER			IN 46402		
	OHONE REALITION	CILLIADILITATION CENTER		·	IIN +U+UZ		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		ne resident required			possible. Based on such		
	extensive assista	ance of one staff member			admission assessments, individualized interventions w	النو	
	for bed transfers	s, bed mobility, and			implemented. New residents		
		oom or corridor. The			be provided adequate superv		
	_	indicated the resident			and appropriate assistance	- 1 - 1	
		with transfers moving			devices to prevent accidents	as is	
	_				possible. Further, an ongoing		
	nom a seated to	a standing position.			facility QA audit will be condu		
	4 E 4 E 4				by charge nurses or designed		
		essment was completed			ensure that interventions initia	ated	
		e resident's score was			continue to be in place, as indicated. Any deviations will	he	
	(22). A score of	f (10) or above indicated			corrected immediately and a		
	the resident was	at risk for falls. The last			cause analysis determined a		
	Fall Risk assess	ment completed prior to			appropriate follow-up initiated		
		npleted on 6/2/14. The			Additionally, staff will be		
		assessment score was			re-educated regarding proper	rly	
		assessment score was			assessing and monitoring		
	also (22).				resident safety issues to ensu		
					that resident environments ar free of accident hazards as is		
		urrent Care Plans were			possible. Further, in-services		
	reviewed. A Ca	are Plan initiated on			shall stress the vital importan		
	3/11/14 indicate	ed the resident has			of adequate supervision,		
	impaired cognit	ion, decreased strength			monitoring and providing		
		and a history of falls.			appropriate assistance device		
		vas last reviewed on			to residents to prevent accide	ents	
		Plan interventions			as is possible. How the		
					corrective action (s) will be		
		resident to have a Dycem			monitored to ensure the		
	in place to the w	vneei chair.			deficient practice will not re	cur,	
					i.e. what quality assurance program will be put into pla	ce?	
		eatment Record indicated			Upon admission, an assessm		
	the following tro	eatments were to be in			form entitled "Initial Resident		
	place included f	for the resident to have			Safety Assessment" will be		
	bed and wheel c	chair alarms in place every			conducted and forwarded to t		
		em pad on the wheel chair			Director of Nursing or design		
	while up in the	•			review for accuracy. Such for		
	winic up in the	wheel chair.			will address interventions for	any	
					potential accident hazards,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155530	B. WIN			02/03/	2015
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	t			LER ST		
SOLITH	SHORE HEALTH &	REHABILITATION CENTER			IN 46402		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ses' Notes were reviewed.			supervision needs and	_ :f	
	An entry made of	on 1/22/15 at 7:00 a.m.			appropriate assistance devices indicated. The QA audit form	5, 11	
	indicated the Nu	rse was called to the			entitled "Ongoing Resident Sa	fetv	
	resident's room.	The CNA stated she had			Assessment" will be initiated b		
	dressed the resid	lent and had been trying			charge nurses or designees.	,	
		nt up into the chair and			Such form will validate that		
	_	on the floor. No injuries			interventions are in place and		
		noted. The resident had			assessed residents' environme		
					continue to be free of accident		
	no complaints of	f pain or discomfort.			hazards as is possible. Additionally, this QA audit forn	,	
					will validate that assessed	'	
	When interviewe	ed on 2/3/15 at 10:15			residents are receiving adequa	ate	
	a.m., LPN #1 inc	dicated the resident was			supervision and appropriate		
	to have a Dycem	pad in place on her			assistance devices to prevent		
	wheel chair.				accidents as is possible. Any		
	Wilcor chair.				deviations will be corrected		
	W/h an indami	- 4 2/2/15 - 4 10-20			immediately and a root cause		
		ed on 2/3/15 at 10:20			analysis determined and		
		dicated she was assigned			appropriate follow-up initiated.  QA audits will be conducted by		
		ent #D. The CNA			charge nurses or designees no		
	indicated she usi	ually worked on another			less than twice daily a minimul		
	hall. The CNA	indicated the resident was			of 5 times per week for 90 day		
	gotten up into th	e wheel chair by the			Thereafter, such QA audits wil		
		The CNA indicated she			conducted not less than once		
	_	care card or instruction			daily for 120 days. The results		
	1	ntions to be in place for			such audits will be reviewed by	у	
		intions to be in place for			the Director of Nursing or		
	Resident #D.				designee and the Quality Assurance Committee for		
					appropriate recommendations		
		ed on 2/3/15 at 1:35 p.m.,			and action, if indicated.		
	CNA #1 also inc	licated she did not			Unannounced random QA aud	dits	
	receive report or	instructions from the			will be conducted not less thar	1	
	Nurse or the nig	ht shift CNA related to			weekly for 60 days by nurse		
	_	s or Dycem pad for the			managers or designees.		
	resident.				Thereafter, such random QA		
	Tosident.				audits will be conducted not le		
	33.71	1 0/0/15 + 1.00			than monthly for 120 days. An deviations will be corrected	у	
	When interviewed	ed on 2/3/15 at 1:30 p.m.,			deviations will be corrected		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріпі	LDING	00	COMPLE	TED
		155530	A. BUII B. WIN			02/03/2	2015
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<b>.</b>	
NAME OF F	PROVIDER OR SUPPLIE	R		353 TYI			
SOUTH	SHORE HEALTH 8	REHABILITATION CENTER			IN 46402		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	the Director of 1	Nursing indicated the			immediately and a root cause		
	resident should	have had the Dycem and			analysis determined and		
	chair alarm in p	lace as per the Physician's			appropriate follow-up initiated. The results of such audits will		
	order and plan of				reviewed by the Director of	De	
					Nursing or designee and the		
	2 The closed :	record for Resident #C			Quality Assurance Committee	for	
		n 2/3/15 at 9:31 a.m. The			appropriate recommendations		
					and action, if indicated. Bywh	at	
	I -	oses included, but were			date the systemic changes		
		ight hip fracture,			will be completed? February	'	
		e forehead, advanced			28, 2015.		
	dementia, altere	ed mental status, seizures,					
	osteoarthritis, an	nd anemia. The resident					
	was admitted to	the facility on 12/24/14.					
	The 12/24/14 N	ursing Admission					
		ed right hip fracture as the					
	resident's admit	• •					
	resident's admit	ting diagnosis					
	Review of the 1	2/24/14 Fall Risk					
	assessment indi	cated the resident's score					
	was (12). The a	assessment indicated the					
	` ′	I falls in the past three					
		s chair bound. The Fall					
		t also indicated if the					
		at high risk for falls a					
		ocol was to be initiated					
	1	d documented on the care					
	plan.						
	Review of the 1	2/24/14 Side Rail					
	Assessment scr	een indicated the resident					
		falls and had an					
	1	ety awareness due to					
	cognitive declin	IC.					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155530	B. WIN			02/03/2015
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		353 TYI		
SOUTH	SHORE HEALTH &	REHABILITATION CENTER			IN 46402	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		iated on 12/25/14				
		ident was at risk for falls				
	related to a histo	ory of falls, decreased				
	safety awareness	s, cognitive impairments,				
	and impaired rar	nge of motion. Care plan				
	interventions inc	cluded to ensure the call				
	light was in reac	h, low bed, floor mats x				
	_	e resident to use the call				
	light for assistan					
	The 12/2014 Nu	rses' Notes were				
		ntry made on 12/24/14 at				
		ted the resident arrived to				
	_					
	I	n ambulance transport.				
	1	ndicated the resident had				
		are with 14 staples intact.				
		ndicated the resident				
	required total ca	re from the staff.				
	The next entry in	n the Nurses' Notes was				
	1	14 at 1:30 a.m. The entry				
		ident was in bed with her				
		the call light was in				
	*	entry was made on				
	12/25/14 at 5:30	•				
		-				
		ident remained in bed				
	_	to the right hip was				
	intact.					
	A	10/05/14 + 0.30				
	1	on 12/25/14 at 9:30 a.m.				
		irse was making round				
		sident on the floor. A				
		ssment was completed,				
	the resident was	able to move three				

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Event ID:

F0SX11

Facility ID: 000369

If continuation sheet Page 7 of 10

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	î ´	TE SURVEY MPLETED
		155530	A. BUIL B. WINC			<del></del> 02/	03/2015
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP	CODE	
SOUTH	SHORE HEALTH &	REHABILITATION CENTER		353 TYL GARY, I	LER ST N 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  S LSC IDENTIFYING INFORMATION)	]	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	COMPLETION DATE
1710		, and the right leg moved		mo	·		DATE
	slowly. No faci						
	complaints of pa	nin were noted. The					
	Physician and fa	mily were notified and					
		to be sent out to the					
	hospital for furth	ner evaluation.					
	An Initial Fall Ir	nvestigation form dated					
		viewed. The form					
	indicated the res	sident fell in her room and					
	was in the bed p	rior to the fall. The form					
	also indicated th	e resident was confused					
	and did not have	e a low bed or bed alarms					
	-	orm also indicated					
		prevent recurrence were					
	to be mats on eit	ther side of the bed.					
	When interview	ed on 2/31/5 at 9:45 a.m.					
	LPN #1 indicate	ed she participated in					
		e Plans and she was did					
	1	Care Plans for Resident					
		or 12/25/14. The MDS					
	`	Set) Nurse was also					
		nis time and indicated she					
	•	ed any Care Plans for the					
		24/14 or 12/25/14. The					
		o indicated staff Nurses					
	were to initiate (admission if nee	-					
ı	aumission ii nee	ucu.					
l		ed on 2/3/15 at 11:20					
ı	· 1	icated she had been					
	_	for Resident #C on the					
	day shift on 12/2	25/14. RN #1 indicated					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

F0SX11

Facility ID: 000369

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530		LDING	NSTRUCTION  00	(X3) DATE COMPI <b>02/03</b> .	LETED
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE LER ST N 46402	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	completed a head that time. The R had a right hip fir place also at that the resident was side and floor m. RN also indicate a low bed though in was in the low regular beds go to placed floor mat they were expect to the facility from also indicated shough any Care after the fall.  When interviewed a.m., the Director when a resident were to complete an Initiation, and update Director of Nursunable to identify 12/25/14 was initiated to the resident of the second complete and the seco	resident on the floor and d to toe assessment at N indicated the resident racture with sutures in time. RN #1 indicated lying on the floor on her ats were not down. The d the resident was not in the regular bed she was rest position that the ro. RN #1 indicated she is after the resident fell as ting the resident to return om the hospital. The RN redid not complete or Plan for the resident report, ital Fall Investigation in the Care Plans. The resident report, ital Fall Investigation in the Care Plans. The reding indicated she was red when the above tiated and/or updated ident's fall.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

F0SX11

Facility ID: 000369

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		155530	B. WING		02/03/	2015
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	353	ET ADDRESS, CITY, STATE, ZIP CODE TYLER ST Y, IN 46402		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE

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